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PROVIDER BULLETIN

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THIS ISSUE

Expansion of Function for ARNPs and Sole Signature on Initial Report for PAs

TO:
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Purpose

This Provider Bulletin communicates recent emergency rules on Advanced Registered Nurse Practitioners (ARNP) and Physicians' Assistants (PAs). The changes are summarized as follows:

- ARNPs can now perform the functions of the attending physician, except rate permanent impairment.
- PAs can have sole signature on the report of accident or physician's initial report for simple industrial injury claims.

Both changes will take place as pilot programs. The ARNP and PA rules are effective July 1, 2004. The ARNP rule expires June 30, 2007. The PA rule expires July 1, 2007.

Department's Report to the Legislature

The authorizing legislation, SHB1691 (chapter 65, Laws of 2004) for the ARNPs, and SB 6356 (chapter 163, Laws of 2004) for the PAs, directs the department to report back to the legislature by December 1, 2006 on the implementation of these Acts and include a discussion of the effects of these Acts on injured worker outcomes, claim costs, and disputed claims.

Process for Public Comment on these new rules

As there was very little time between when the legislature passed these bills and the effective date of July 1, 2004, the department must adopt emergency rules in order to fully implement these changes on time. The department will adopt permanent rules on these subjects in the near future. This will allow interested persons to comment on the language of the rules and to allow the department to amend these rules, as needed, based on public comment.

Full Text of the Emergency Rule

The full text of the changes made to the industrial insurance rules and the medical aid rules are as follows. Please note that we tried to make most of the changes within one WAC section for the ARNPs and another for the PAs. This will allow us to easily repeal the changes if the legislature does not extend these Acts in 2007. However, if the legislature extends these Acts, we plan to make more extensive changes to the language of the medical aid rules.

WAC 296-14-400 Reopenings for benefits. The director at any time may, upon the workers' application to reopen for aggravation or worsening of condition, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. This provision will not apply to total permanent disability cases, as provision of medical treatment in those cases is limited by RCW 51.36.010.

The seven-year reopening time limitation shall run from the date the first claim closure becomes final and shall apply to all claims regardless of the date of injury. In order for claim closure to become final on claims where closure occurred on or after July 1, 1981, the closure must include documentation of medical recommendation, advice or examination. Such documentation is not required for closing orders issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall for the purposes of this section only, be deemed issued on July 1, 1985.

The director shall, in the exercise of his or her discretion, reopen a claim provided objective evidence of worsening is present and proximately caused by a previously accepted asbestos-related disease.

In order to support a final closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner ~~supervised by a doctor~~. The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

For the purpose of this section, a "doctor" is defined in WAC 296-20-01002.

When a claim has been closed by the department or self-insurer for sixty days or longer, the worker must file a written application to reopen the claim. An informal written request filed without accompanying medical substantiation of worsening of the condition will constitute a request to reopen, but the time for taking action on the request shall not commence until a formal application is filed with the department or self-insurer as the case may be.

A formal application occurs when the worker and doctor complete and file the application for reopening provided by the department. Upon receipt of an informal request without accompanying medical substantiation of worsening of the worker's condition, the department or self-insurer shall promptly provide the necessary application to the worker for completion.

If, within seven years from the date the first closing order became final, a formal application to reopen is filed which shows by "sufficient medical verification of such disability related to the accepted condition(s)" that benefits are payable, the department, or the self-insurer, pursuant to RCW 51.32.210 and 51.32.190, respectively shall mail the first payment within fourteen days of receiving the formal application to reopen. If the application does not contain sufficient medical verification of disability, the fourteen-day period will begin upon receipt of such verification. If the application to reopen is granted, compensation will be paid pursuant to RCW 51.28.040. If the application to reopen is denied, the worker shall repay such compensation pursuant to RCW 51.32.240.

Applications for reopenings filed on or after July 1, 1988, must be acted upon by the department within ninety days of receipt of the application by the department or the self-insurer. The ninety-day limitation shall not apply if the worker files an appeal or request for reconsideration of the department's denial of the reopening application.

The department may, for good cause, extend the period in which the department must act for an additional sixty days. "Good cause" for such an extension may include, but not be limited to, the following:

(1) Inability to schedule a necessary medical examination within the ninety-day time period;

(2) Failure of the worker to appear for a medical examination;

(3) Lack of clear or convincing evidence to support reopening or denial of the claim without an independent medical examination;

(4) Examination scheduled timely but cannot be conducted and a report received in sufficient time to render a decision prior to the end of the ninety-day time period.

The department shall make a determination regarding "good cause" in a final order as provided in RCW 51.52.050.

The ninety-day limitation will not apply in instances where the previous closing order has not become final.

WAC 296-20-01002 Definition

States in part:
Doctor: For these rules, means a person licensed to practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry.

Only those persons so licensed may sign report of accident forms and certify time-loss compensation except as provided in ~~chapter 296-20~~ WAC 296-20-01502 "When can a physician's assistant have sole signature on the report of accident or physician's initial report?" and WAC 296-23-241 "Can advanced registered nurse practitioners independently perform the functions of an attending physician?"

WAC 296-20-01501 Physician's assistant rules. (1) Physicians' assistants may perform only those medical services in industrial injury cases~~,~~ for which the physician's assistant is trained and licensed, under the control and supervision of a licensed physician. Such control and supervision shall not be construed to require the personal presence of the supervising physician.

(2) Physicians' assistants may perform those medical services which are within the scope of their physician's assistant license for industrial injury cases within the limitations of subsection (3) of this section.

(3) Advance approval must be obtained from the department to treat industrial injury cases. To be eligible to treat industrial injuries, the physician's assistant must:

(a) Provide the department with a copy of his/her license.

(b) Provide the name and address and specialty of the supervising physician.

(c) Provide the department with the evidence of a reliable and rapid system of communication with the supervising physician.

(4) Physicians' assistants may prepare report of accident, time loss compensation certification, and progress reports for the supervising physician's signature. Physicians' assistants cannot submit such information under his/her signature. Under certain circumstances, physicians' assistants can submit the report of accident or physician's initial report under his or her signature. See WAC 296-20-01502.

WAC 296-20-01502 When can a physician's assistant have sole signature on the report of accident or physician's initial report?

(1) Physicians' assistants (PAs) may complete and have sole signature on the report of accident or the physician's initial report, where applicable, on simple industrial injury claims. This can occur for the period beginning July 1, 2004 and ending July 1, 2007.

PAs cannot certify entitlement to time-loss compensation, pension benefits, death benefits, or loss-of-earning power benefits.

(2) A simple industrial injury claim would include:

- No time lost from work after the date of injury; and
- A simple industrial injury limited to an insect bite, abrasion, contusion, laceration, blister, foreign body, open wound, sprain, strain, closed fracture, simple burn, or probable exposure to bloodborne pathogen due to a needle stick.
  (Specific examples include 2nd degree burn, ICD-9 943.29, tibia fracture, closed, ICD-9 823.80.)

A simple industrial injury does not involve:

- Time lost from work after the date of injury; or
- Surgery or hospitalization on the date of the injury or date of first treatment; or
- Occupational diseases (e.g., dermatitis, carpal tunnel syndrome, hearing loss, asbestosis, exposure to blood with no needle stick); or
- Complex industrial injuries (e.g., hernias, head injuries (except simple lacerations or abrasions), mental health conditions, open fractures, extremity amputation, severe crush injuries, severe burns, spinal cord injuries, cancer, heart disease, stroke or chemical exposure.)

(3) An attending physician must be assigned to the claim to certify any time off work after the date of injury.

(4) The PA must identify on the report of accident or physician's initial report the name of the doctor who will be supervising care under this claim and also list the corresponding Labor & Industries provider number for that doctor. The claim will be considered on its own merits regardless of the absence of the supervising physician's L&I number but payment of bills may be delayed.

(5) WAC 296-20-01502 expires July 1, 2007.

WAC 296-20-06101 What reports are health care providers required to submit to the insurer? The department or self-insurer requires different kinds of information at various stages of a claim in order to approve treatment, time-loss compensation, and treatment bills. The department or self-insurer may request the following reports at specified points in the claim. The information provided in these reports is needed to adequately manage industrial insurance claims.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Report of Industrial Injury or Occupational Disease (form) **Self-Insurance: Physician's Initial Report** (form)	Immediately - within five days of first visit.	See form If additional space is needed, please attach the information to the application. The claim number should be at the top of the page.	Only MD, DO, DC, ND, DPM, DDS, ARNP, and OD may sign and be paid for completion of this form. PAs may sign and be paid for completion of this form under the circumstances outlined in WAC 296-20-01502.
Sixty Day (narrative) **Purpose:** Support and document the need for continued care when conservative (nonsurgical) treatment is to continue beyond sixty days	Every sixty days when only conservative (nonsurgical) care has been provided.	(1) The **conditions diagnosed,** including ICD-9-CM codes and the subjective complaints and objective findings.	Providers may submit legible comprehensive chart notes in lieu of sixty day reports **PROVIDED** the chart notes include all the information required as noted in the "What Information Should Be Included?" column.
		(2) The **relationship of diagnoses,** if any, to the industrial injury or exposure. (3) Outline of **proposed treatment program,** its length, components and expected prognosis including an **estimate of when treatment should be concluded** and condition(s) stable. An **estimated return to work date** and the **probability,** if any, **of permanent partial disability** resulting from the industrial condition.	**However,** office notes are not acceptable in lieu of requested narrative reports and providers may not bill for the report if chart notes are submitted in place of the report. Please see WAC 296-20-03021 and 296-20-03022 for documentation requirements for those workers receiving opioids to treat chronic noncancer pain.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
		(4) **Current medications,** including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication. (5) If the worker has not returned to work, **indicate whether a vocational assessment will be necessary** to evaluate the worker's ability to return to work and why. (6) If the worker has not returned to work, a **doctor's estimate of physical capacities** should be included. (7) **Response to any specific questions** asked by the insurer or vocational counselor.	Providers must **include** their **name, address and date** on all chart notes submitted.
Special Reports/Follow-up Reports (narrative)	As soon as possible following request by the department/insurer.	**Response to any specific questions** asked by the insurer or vocational counselor.	"Special reports" are payable only when requested by the insurer.
Consultation Examination Reports (narrative) **Purpose:** Obtain an objective evaluation of the need for ongoing conservative medical management of the worker. The attending doctor may choose the consultant.	At one hundred twenty days if only conservative (nonsurgical) care has been provided.	(1) Detailed history. (2) **Comparative history** between the history provided by the attending doctor and injured worker. (3) Detailed physical examination. (4) **Condition(s) diagnosed** including ICD-9-CM codes, subjective complaints and objective findings.	If the injured/ill worker had been seen by the consulting doctor within the past three years for the same condition, the consultation will be considered a follow-up office visit, not consultation. A copy of the consultation report must be submitted to both the attending doctor and the department/insurer.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
		(5) Outline of **proposed treatment program:** Its length, components, expected prognosis including when treatment should be concluded and condition(s) stable. (6) **Expected degree of recovery** from the industrial condition. (7) **Probability of returning to regular work** or modified work and an **estimated** return to work **date.** (8) **Probability,** if any, of **permanent partial disability** resulting from the industrial condition. (9) A doctor's **estimate of physical capacities** should be included if the worker has not returned to work. (10) **Reports** of necessary, reasonable **X ray** and **laboratory** studies to establish or confirm diagnosis when indicated.	
Supplemental Medical Report (form)	As soon as possible following request by the department/insurer.	See form	Payable only to the attending doctor upon request of the department/insurer.
Attending Doctor Review of IME Report (form) **Purpose:** Obtain the attending doctor's opinion about the accuracy of the diagnoses and information provided based on the IME.	As soon as possible following request by the department/insurer.	Agreement or disagreement with IME findings. If you disagree, provide objective/subjective findings to support your opinion.	Payable only to the attending doctor upon request of the department/insurer.
Loss of Earning Power (form) **Purpose:** Certify the loss of earning power is due to the industrial injury/occupational disease.	As soon as possible after receipt of the form.	See form	Payable only to the AP.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Application to Reopen Claim Due to Worsening of Condition (form) **Purpose:** Document worsening of the accepted condition and need to reopen claim for additional treatment.	Immediately following identification of worsening after a claim has been closed for sixty days. **Crime Victims:** Following identification of worsening after a claim has been closed for ninety days.	See form	Only MD, DO, DC, ND, DPM, DDS, ARNP, and OD may sign and be paid for completion of this form.

What documentation is required for initial and follow up visits?
Legible copies of office or progress notes are required for the initial and all follow-up visits.

What documentation are ancillary providers required to submit to the insurer?
Ancillary providers are required to submit the following documentation to the department or self-insurer:

Provider	Chart Notes	Reports
Audiology	X	X
Biofeedback	X	X
Dietician		X
Drug Alcohol Treatment	X	X
Free Standing Surgery	X	X
Free Standing Emergency Room	X	X
Head Injury Program	X	X
Home Health Care		X
Infusion Treatment, Professional Services		X
Hospitals	X	X
Laboratories		X
Licensed Massage Therapy	X	X
Medical Transportation		X
Nurse Case Managers		X
Nursing Home	X	X
Occupational Therapist	X	X
Optometrist	X	X
Pain Clinics	X	X
Panel Examinations		X
Physical Therapist	X	X
Prosthetist/Orthotist	X	X
Radiology		X
Skilled Nursing Facility	X	X
Speech Therapist	X	X

WAC 296-23-240 Licensed nursing rules. (1) Registered nurses and licensed practical nurses may perform private duty nursing care in industrial injury cases when the attending physician deems this care necessary. Registered nurses may be reimbursed for services as outlined by department policy. (See chapter 296-20 WAC for home nursing rules.)

(2) Advanced registered nurse practitioners (ARNPs) may perform advanced and specialized levels of nursing care on a fee for service basis in industrial injury cases within the limitations of this section. ARNPs may be reimbursed for services as outlined by department policy.

(3) In order to treat workers under the Industrial Insurance Act, the advanced registered nurse practitioner must be:

(a) Recognized by the Washington state board of nursing or other government agency as an advanced registered nurse practitioner (ARNP). For out-of-state nurses an equivalent title and training may be approved at the department's discretion.

(b) Capable of providing the department with evidence and documentation of a reliable and rapid system of obtaining physician consultations.

(4) Billing procedures outlined in the medical aid rules and fee schedules apply to all nurses.

WAC 296-23-241 Can Advanced Registered Nurse Practitioners Independently Perform the Functions of an Attending Physician?

Advanced registered nurse practitioners (ARNPs) may for the period of July 1, 2004 through June 30, 2007, independently perform the functions of an attending physician under the Industrial Insurance Act, with the exception of rating permanent impairment. These functions are referenced in the medical aid rules as those of a physician, attending physician, or attending doctor and include but are not limited to:

- Completing and signing the report of accident or physician's initial report, where applicable,
- Certifying time-loss compensation,
- Completing and submitting all required or requested reports,
- Referring workers for consultations,
- Performing consultations,

- Facilitating early return to work offered by and performed for the employer(s) of record,
- Doing all that is possible to expedite the vocational process, including making an estimate of the worker's physical or mental capacities that affect the worker's employability.

ARNPs can state whether a worker has permanent impairment, such as on the department's Physician's Final Report (PFR). ARNPs cannot rate permanent impairment or perform independent medical examinations (IMEs).

WAC 296-23-241 expires on June 30, 2007.